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THE BAMAKO INITIATIVE

Progress report

SUMMARY

The present report describes the progress made with preparatory activities and individual country programmes for implementing the Bamako Initiative. It discusses the contribution made by the Initiative to the provision of an accessible, affordable and sustainable health care delivery system in sub-Saharan Africa as well as in other regions of the world. A core group of 12 countries is well into full-scale implementation, while an additional 15 countries have either initiated preparatory action or an in-depth assessment of the prevailing health delivery system. The report analyses continuing constraints, both programmatic and operational, to implementation, and gives examples of increased attention to monitoring, evaluation and operations research.

As recommended by the Executive Board at its 1990 session, UNICEF has channelled additional general resources to several countries under full implementation of the Initiative. Some initial donor support has been received, but there continues to be an urgent need for additional donor support in order to maintain the achievements made to date and to respond to the increasing financial contribution provided by communities themselves.

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INTRODUCTION

1. The historic World Summit for Children, held on 30 September 1990, has generated an unprecedented level of commitment by the world community to improve the situation of children and women based on a definite set of goals. In the 1980s, universal child immunization (UCI) and the control of diarrhoeal diseases (CDD) were the principal elements of UNICEF cooperation in maternal and child health (MCH), thus enabling health services in many countries to demonstrate significant accomplishments and providing the basis for an organizational model. The health goals of the 1990s, however, go far beyond UCI and CDD, entailing a major effort in capacity-building to establish health services that are accessible, appropriate and sustainable. Only with such strong peripheral health care systems will countries be able effectively to address old problems such as malaria, acute respiratory infections (ARI), low birth weight and perinatal trauma, and new ones, specifically acquired immunodeficiency syndrome (AIDS), that threaten to slow the gains already made in improving infant and child survival and the health and nutrition of children and women.

2. The ambitious goal to improve health status contrasts, however, with the crisis conditions actually prevailing in health care delivery systems in Africa and in many other parts of the world. People have lost confidence in public sector health services where drugs are often unavailable and the quality of care is poor. Patients may either seek alternative, frequently high-cost, care or deny themselves treatment.

3. The Bamako Initiative is a major post-Summit strategy for reviving, strengthening and extending such beleaguered basic health care services, particularly at the district level and below, thus addressing the health goals of the 1990s and responding to the challenge of Health for All by the year 2000. Its key challenge, given the prolonged economic crisis, is to mobilize additional resources for health, while at the same time expanding service coverage to meet the needs of those still without access to basic health care. Emphasizing MCH, the Initiative integrates a wide range of individual health interventions, such as UCI, CDD, pre- and post-natal care, and the prevention and control of malaria, ARI and AIDS. The difference with the Bamako Initiative is that it ties the revival and strengthening of these basic health services to the people's greater participation and control, which was a key element in the Alma Ata declaration on primary health care (PHC). Local ownership makes services more effective and more appropriate to local conditions, with the finances generated being managed by the communities themselves.

4. During 1990, continued advocacy and action, both in individual countries and within international forums, further enhanced the development of the Initiative. UNICEF and the World Health Organization (WHO) have continued to collaborate closely. This is most evident at the country level often through joint involvement in national task forces overseeing preparatory work and eventual implementation. In June 1990, the Pan-African Conference on the

Financing of Community Health Activities, organized by the WHO Regional Office for Africa, in collaboration with UNICEF, and attended by over 150 African health experts, reinforced the conviction of African countries that the Bamako Initiative was essential in reaching health goals and making PHC universally accessible (see the annex for the Kinshasa Declaration).

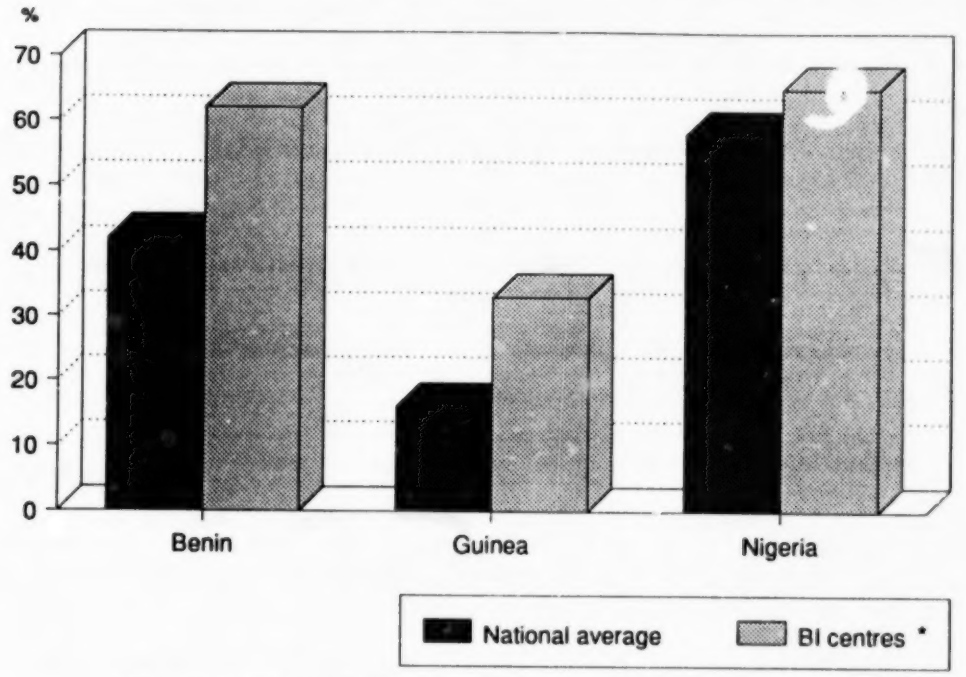
5. The 1980s were not without successes in health development. Progress was made in UCI; significant numbers of health services run by non-governmental organizations (NGOs) provided care; essential drugs programmes were established, in some cases on the basis of revolving drug funds; and interventions for specific diseases were targeted. The consolidation of those efforts into coherent district-based health systems, with community involvement in their management and financing, is viewed as the way to establish services that can be sustained even in the most difficult economic, social and political circumstances. The importance of focusing on the long-term needs of African health is receiving the growing support of international development agencies. The increasing prominence of the World Bank in African health development has been especially noticeable in 1990, along with the growing involvement of the European Communities (EC).

6. Within UNICEF country programmes of cooperation in sub-Saharan Africa, the Initiative, as recommended by the Executive Board at its 1990 session (decision 1990/15) is becoming the core of health sector support. At the 1991 session of the Executive Board, seven countries (Cameroon, Equatorial Guinea, Ghana, Guinea, Nigeria, Sao Tome and Principe and Zambia) are presenting new country programme recommendations and one (Zaire) is presenting a bridging programme, with the Bamako Initiative as a major component. These will significantly increase UNICEF commitment to the Initiative, through both general resources and supplementary funding.

7. The Initiative is beginning to benefit from an improved information base. Situation analyses are increasingly being carried out at the district level, a need that WHO had been stressing for several years. Sierra Leone, for example, has already completed detailed health analyses in 4 of 13 districts that will lead to more accurate planning and eventually to an in-depth national assessment and health plan for the medium term. Monitoring systems in several countries, such as Benin, Guinea and Nigeria, are tracking major trends, especially the levels of community financing, utilization of services, types of care provided and essential drugs used. Of note is evidence from Benin and Guinea that points to higher immunization coverage in areas under the Initiative, suggesting that the Initiative can help to sustain UCI in the long term (see figure 1). Operations research is also analysing such issues as the savings the Initiative may make possible in Mauritania from lower transport costs in households seeking medical care or drugs, as well as examining health habits, practices and costs of care in Sierra Leone.

Figure 1

Immunization coverage with DPT3 in selected countries, 1989



* "BI centres" refer to those areas where health centres have been revitalized under the Bamako Initiative

I. CONCEPT

8. The original resolution, passed by the African ministers for health meeting at Bamako, provided a clear orientation in aiming: (a) to accelerate PHC; (b) to give priority to women and children; (c) to define and implement self-financing mechanisms at the district level; (d) to encourage social mobilization for community participation in MCH and PHC; (e) to enable communities to be principal partners in health care development; and (f) to ensure regular supplies of essential drugs.

9. Guidelines elaborated jointly by WHO and UNICEF, and later approved by the ministers for health in 1988, have remained valid. WHO and UNICEF support is dependent on a country's interest in and adherence to the following basic principles:

(a) National commitment to accelerating the provision of universally accessible PHC services;

(b) Substantial decentralization to the district level of the health ministry's decision-making for the management of PHC;

(c) Decentralized management of community resources, thereby allowing the funds collected at local facilities to remain under community control;

(d) The application of consistent principles governing community financing for health care services throughout the different levels of the health system, making it inappropriate to provide free service at urban hospitals while requiring payment for community-based services;

(e) Substantial government financial support for PHC to ensure that the health budget is maintained at least at its current level of support to district and local services;

(f) Policies on essential drugs that are compatible with, and complementary to, the rational development of PHC;

(g) Measures for ensuring that the poorest people have access to PHC services;

(h) The clear definition of intermediate health system and management objectives and the establishment of indicators to measure them.

10. The relationship between the Initiative and PHC is very specific. In placing responsibility for PHC at the local level, but with continuing technical support and supervision from national, regional and district levels, four key components are highlighted:

(a) The basic health care delivery system is the principal focus of the Initiative, through which the majority of health care interventions, particularly those for mothers and children, can be provided. The role of the district hospital in both supervision and referral is recognized at the same time as no less crucial, considering also that it provides direct care to mothers and children in the urban population;

(b) The role of essential drugs is pivotal in basic care for treating such prevalent illnesses as malaria, ARI, diarrhoea, parasitic infections, and for helping to prevent such conditions as anaemia during pregnancy. Ensuring that affordable, essential drugs are readily available under controlled prescribing conditions in health facilities both builds trust in and reliance on health facilities and protects people from the drugs and substances, often of dubious quality, so readily available in local markets;

(c) The financing of basic health services occupies a prominent place in any assessment of health sector constraints. Expenditures on health have declined in many countries, resulting in a breakdown of health services. The most critical effect has been the loss of workers from the health system in response to salaries whose purchasing power has been eroded, or which even frequently go unpaid. It is clear that health services cannot be revived without attention to the fact that only well-motivated health workers can provide appropriate services. Cost-sharing, with community financing playing an important role, is being adopted in most countries unable to run health

services through government funding alone. The guiding principles of the Initiative, however, emphasize the need to maintain and possibly increase national expenditures on PHC;

(d) The degree of community involvement in the management and financing of local health services is the main indicator of the success of the Initiative. The community, as a full partner in health care, develops a greater awareness of better health practices, especially for children and women. Local health committees either grow out of existing development committees or act as initial focal points of local involvement in development. Although community financing, with the funds managed by the communities themselves, can contribute significantly towards meeting the local costs of services, community self-sufficiency is not the aim of the Bamako Initiative. Rather, the aim is to foster a partnership in health services' management between the community and the Government.

II. PRINCIPAL ISSUES

11. As reported in the past, the Bamako Initiative, fraught with difficulties and constraints, is not an easy undertaking, especially given the severe economic conditions in sub-Saharan Africa and the fragility of many public sector institutions. Because Governments are unable to respond to many of the needs, it is essential that more reliance be placed on community structures. Nevertheless, it is recognized that these structures are changing with rapid urbanization and the increasing temporary or permanent migration of wage earners in search of work and, thus, this presents an additional challenge. Moreover, the democratization taking place in many African countries, while enhancing local action in development, could at the same time further marginalize the poorest segments of society, which would be the least likely to benefit from new economic systems. These and other factors underscore how difficult it is to predict overall development trends in Africa and complicate the revival of the continent's health sector.

A. Health care delivery system

Situation of health workers

12. The low salaries of health workers - who sometimes are not paid at all - constitute perhaps the most severe constraint in reviving and extending health services in sub-Saharan Africa. Any attempt to provide quality care through local health services is seriously undermined when health workers, faced with the need to survive, either dedicate themselves to parallel private sector practice, including the sale of drugs, or spend much of their time at other occupations. To expect the health worker to be an educator and motivator under such conditions is unrealistic. Nevertheless, their dedication is not to be underestimated and even small incentives, as now provided under the Initiative in Benin and Guinea from community financing, have substantially increased the quality of service. The prime responsibility for the payment of

health workers' salaries, however, still lies with Governments, and the Initiative strongly emphasizes this.

Decentralization

13. The Initiative, perhaps more than anything else, is aimed at national capacity-building as it attempts to rationalize the type of health services being provided and how they are operated. The emphasis on providing services at the district level illustrates the need for more rapid decentralization. In Kenya and Sierra Leone, one approach is having success in this capacity-building effort that emphasizes decentralization. Detailed district situation analyses are prepared that highlight not only the health problems and needs in each district, but also the differences from district to district in terms of epidemiology, infrastructure, leadership and other key factors that point to the need for greater district-level decision-making. The added advantage of such detailed situation analyses is that collectively they form a comprehensive assessment of the health situation in the country, thus supporting the development of long-term national health development plans. Nevertheless, while such positive examples of effective decentralization can be found, many countries are still reluctant to divest authority over certain controls, notably financial management.

Human immunodeficiency virus/acquired immunodeficiency syndrome

14. The impact of human immunodeficiency virus (HIV)/AIDS on health services is growing, particularly in high-incidence countries. A large percentage of the bed capacity in health facilities is taken up by AIDS patients, thus resulting in a significant concentration of resources for their care. Infected infants and children arrive at health facilities ill from opportunistic diseases, but fail to respond to normal treatment. The strain on the health care system from HIV/AIDS makes it more urgent than ever that the system be strengthened, upgraded and extended as quickly as possible, with health workers being key agents in education on HIV/AIDS prevention.

Reaching the unreached

15. Currently, one half of the population on the African continent has no access to even minimal formal health services. Correcting this inequity requires accelerated national planning and the identification of resources with which to extend the basic health care system. While community financing represents a new source of funding for health care, it will not be enough for the rapid expansion needed. External resources will have to play a far greater role than in the past, joining in a dynamic government-community-donor partnership that can help to implement the national health development plans gradually taking shape in some of the countries moving forward with the Initiative.

Environment and population

16. One of the Initiative's principal objectives is to reduce infant and child mortality rates. Reducing under-five mortality is an important step

towards reducing the population growth rate, as parents gain confidence that their children will not die and leave them alone or destitute in sickness or old age. In addition, the system for supplying essential drugs is increasingly being used by Governments to distribute other items, including family planning supplies. In the initial demonstration areas in Kenya, for example, village pharmacies stock not only the essential drugs dispensed by community health workers (CHWs), but also insecticide-impregnated mosquito nets, which are sold to the public, and condoms, which are available free of charge. Such an arrangement facilitates the offering of family planning advice to those who seek it and makes the eventual reduction of HIV transmission possible. Furthermore, it is expected that as communities begin to accumulate funds and deepen their understanding of their situations and the reasons for them, they will improve their environment by supporting actions in such areas as water supply, sanitation and reforestation.

B. Essential drugs management

Rational use of drugs

17. The appropriate use of drugs remains a key area of concern in a revitalization process that puts emphasis on an assured supply of essential drugs. The preparation of standard protocols for diagnosis and case management continues to be a priority for improving rational prescribing, and several countries, such as Cameroon and Mauritania, have followed the lead set by Benin, Guinea and Nigeria in this area. Patient demands for drugs however, continue to be unrealistic in many instances. The widespread availability of drugs from peddlers or local markets is a major impediment to instituting better prescribing and consumption practices, as patients who are dissatisfied with the range and nature of drugs available from health services can immediately turn to these alternative sources. Consumer education and the way it is undertaken both within and outside the health system is, therefore, of immediate concern and a priority action for the future.

National drug policies

18. WHO has continued to pursue the adoption of national drug policies in various countries, such as Guinea and Mali. UNICEF has also been involved in extensive reviews of the pharmaceutical sector in Rwanda and Sao Tome and Principe. The World Bank and the African Development Bank (AfDB) are increasingly involved in either restructuring the pharmaceutical sector, leading to increased local capacity for drug production, or granting loans for essential drugs inputs, and their support will have considerable impact on the establishment of national policies. External sources still provide the majority of drugs used in the public sector so decisions on foreign exchange needs have remained in the background. UNICEF in-country advocacy, especially among political leaders, parliamentarians and other decision makers, has, nevertheless, continued to highlight this pending need.

C. Community financing

National policy

19. The prolonged economic crisis has meant that national budgets have not increased, and the likelihood of any significant growth is remote. The main strategy of national policy, therefore, has been to introduce cost-sharing, usually in the form of user fees for health care. At the same time, it is now accepted that public sector service quality must improve before significant local financing can be stimulated. The Initiative addresses such improvement very specifically through a series of actions in training and supervision, community involvement and improved case management. Donor support is most critical in these actions during the start-up period, which can take from several months to years, depending on social, cultural and economic constraints.

20. UNICEF has continued to support countries, in collaboration with WHO, the World Bank, bilateral agencies and NGOs, in assessing the broad aspects of their health sector financing with a view to alternative sources and improved management of funds. In Uganda, UNICEF has contributed to policy discussions through its work with the national health financing task force. In Zambia, the focus has been on existing community financing schemes and their role in the evolving national health financing process.

Financing mechanisms and equity

21. The experience in many countries proves that patients are willing to pay for what they consider a reasonable quality of care, corroborating what many NGOs, notably mission hospitals and health centres, have known and practised for a long time. However, no hard and fast rules can be applied to community financing, and different communities will have different goals and levels of performance. Kenya, for example, has taken a broad approach with women's income-generating activities such as basket weaving, complementing funds generated in the village pharmacy.

22. Initial operations research on the ability to pay in Sierra Leone, for example, is beginning to show that even poor households hold cash in reserve for emergencies such as health care. If the need is greater than their reserve, however, they may have to sell assets, typically foodstuffs, to generate additional resources. 1/ This may have a negative short-term impact on the family. On the other hand, evidence seems to be mounting that the Initiative, by placing affordable treatment with essential drugs closer to the consumer, will begin to reduce direct household expenditures on health care.

23. This suggests that the Initiative will improve access to care for the poor. However, the issue remains of those who, because they are unable to pay for care, therefore deny themselves treatment. Community action still seems to be the most appropriate way of protecting the poorest in the sense of solidarity, and consistent observation in rural areas in several countries tends to support this view. Research has been initiated in Benin and

Mauritania on this specific issue, but no conclusions have yet been reached to assess the degree to which the poor are excluded from using health services owing to financial constraints.

Use of community funds

24. Because donor inputs cover the costs of most essential drugs requirements in the first years of the Initiative, some countries are accumulating and holding funds in local bank accounts. Small amounts are used to pay some local operating costs, including incentives for health workers, but most of the accumulated capital is unused. Such accumulation, even for relatively short periods, however, presents great risks, particularly from inflation, and constant vigilance is required to avoid loss. Interestingly, some reinvestment of community funds is beginning, such as the use of funds in one village in Mauritania to buy tools for a women's cooperative.

D. Community involvement

25. Community action is at the heart of the Initiative, and the Initiative supports community involvement at each of the various levels of health care delivery. Where local government is effectively organized, such as in Nigeria, there is already popular participation in the existing councils, and health issues, particularly concerning children and women, are emphasized.

Role of women

26. The specific attention focused on women by the Initiative does not change the fact that they play a very limited role in decision-making at the local level. Men still dominate local committees and thus control decisions about health care organization and delivery, as well as those affecting the use of community funds, including funds for health that often come directly from budgets contributed by women. In some ways, therefore, moving rapidly ahead to provide basic health care for women and their children could be argued as ignoring the more long-term process of increasing women's decision-making role. The assumption guiding the Initiative, however, is that improvements in health and welfare are the first step for improving the lives of women and girls. Improved child survival rates eventually lead to reduced numbers of pregnancies, and easier access to water supplies can ultimately help improve women's and girls' economic and educational opportunities. Nevertheless, this area will require constant monitoring and research to determine whether progress in health does improve the status of women in the long term.

Urban community

27. The Initiative is primarily recognized as a strategy to revive rural health services. Yet, although access to health care is generally easier in urban areas, at least in physical if not financial terms, Africa is a rapidly urbanizing continent and the Initiative will have to give increasing attention to the health needs of urban populations, especially those on the social and

economic margins. In collaboration with other donors, more focus on the district hospital is slowly being introduced, with such action as the rehabilitation of MCH wards in Sierra Leone, with UNICEF support. In the same country, work has already started on the Initiative in the Western Area, where Freetown, the capital, is located.

III. COUNTRY ACTION

A. Experiences of 12 core countries

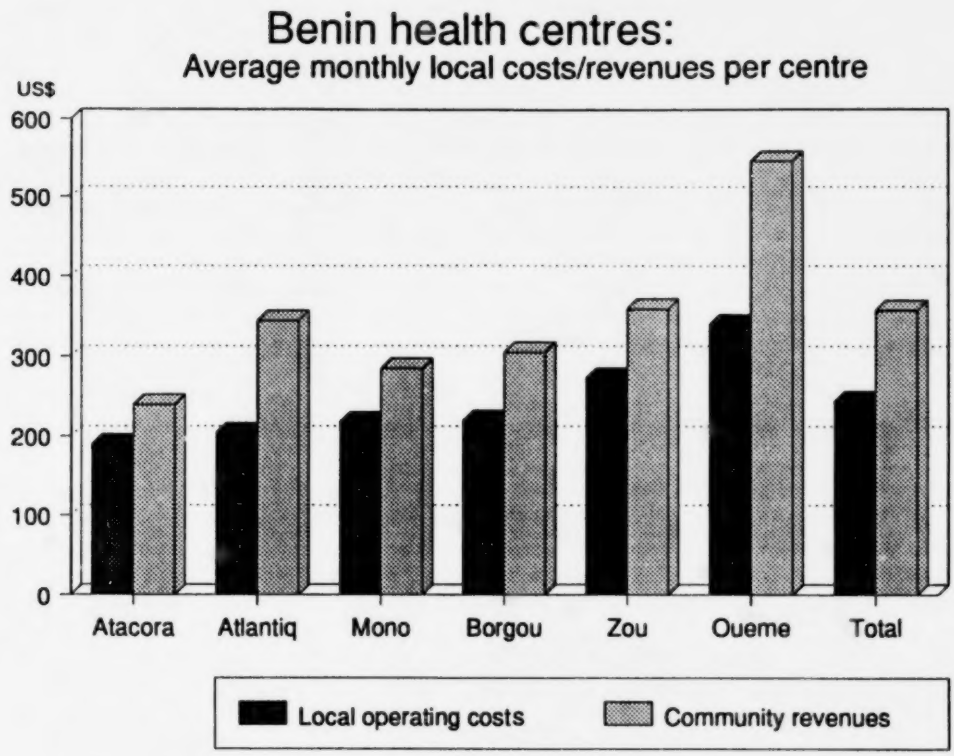
28. Since the Bamako Initiative was formulated, its influence has been felt in most countries in sub-Saharan Africa. By late 1990, in particular, a core group of 12 countries had reached clear definitions of the Initiative, largely in accordance with its guiding principles, but taking into account the social, economic and political situations in each country. The 12 have moved forward or are about to initiate field-level implementation, each building upon many long-standing forms of community action.

Benin

29. In Benin, the Initiative has become the national health strategy. Of the 400 commune (subdistrict) health centres in the country, 375 are at some stage of implementing the Initiative, 200 with UNICEF assistance and the rest with the assistance of other donors, particularly bilateral assistance from the Governments of Germany, the Netherlands and Switzerland. Meetings between the Government and donors, including also WHO and the World Bank, are held every three months to coordinate action, and resulted in joint support to a Drug Procurement Unit in the Ministry of Health.

30. The present emphasis of health services is on providing immunization, oral rehydration therapy (ORT), basic curative care and pre-natal care. Coverage for immunization and pre-natal care of the populations with access to the centres stands between 60 and 70 per cent. A comprehensive evaluation of the Initiative, held in March 1990, demonstrated the continuing progress in quality and coverage of basic health care services and in community financing and management (see figure 2). In general, attempting to reach those who live far from a health centre and extending health services into the 100 or so communes lacking health facilities are the main challenges now facing the Initiative in Benin.

Figure 2



Data were taken from 166 health centres from July to December 1989.

Burundi

31. Significant progress has been made with the Government of Burundi in terms of programme development, under the leadership of a technical task force for the Bamako Initiative. A specific proposal for supplementary funding is being presented to the Executive Board at its 1991 session (E/ICEF/1991/P/L.24) as a result of the in-depth assessment and planning in 1990 involving, among others, staff at the Institute of Tropical Medicine at Antwerp, Belgium, who provided technical assistance. Burundi's health insurance, the Carte d'assurance maladie, can be purchased by a household on a yearly basis and covers fees at medical facilities. However, it is estimated that less than 20 per cent of people use the Carte d'assurance maladie owing primarily to the poor quality of care in health centres. Additionally, the revenues generated from the Carte d'assurance maladie go directly to the district government, which is not obliged to use them for health financing, thus discouraging broader participation. Nevertheless, the Carte d'assurance maladie provides an important base for implementing the Initiative and one district, Muyinga, has started specific action in this regard.

Cameroon

32. In October 1989, the Government of Cameroon reoriented its national health policy to PHC, following a national seminar that assessed the prevailing status of health and health care delivery in the country. Many of the strategies adopted fall within the guiding principles of the Initiative and, although no national plan exists, several programmes are being implemented, with notable bilateral cooperation from Germany, the United States Agency for International Development (USAID) and EC. An intersectoral committee exists for PHC, a subcommittee of which, with WHO and UNICEF participation, is working out action plans for the Initiative. A new country programme recommendation is being presented to the Executive Board at its 1991 session (E/ICEF/1991/P/L.6), with the Initiative as a central component of health sector development. It will be initiated in 22 subdistricts and eventually reaching 158 subdistricts, covering about 1.6 million people, or 13 per cent of the total population.

Equatorial Guinea

33. Preparatory action in Equatorial Guinea started in 1990. Accelerated UCI action has resulted in the strengthening of supply logistics systems, an important prerequisite for the start-up of the Initiative. The training of health staff has taken place at national and district levels. Implementation will begin in 1991 in selected health facilities. The Initiative is the basis of the health sector component of the new country programme being presented to the 1991 Executive Board (E/ICEF/1991/P/L.20). Key health interventions will build on immunization and consolidate action in CDD before introducing activities in the prevention and control of ARI and growth monitoring and promotion.

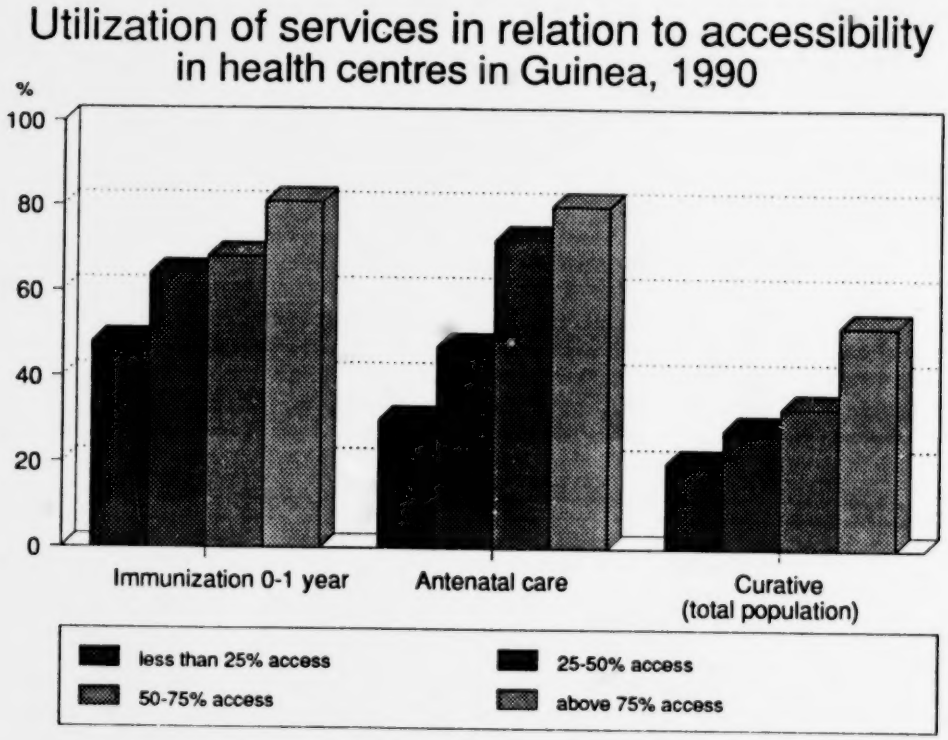
Guinea

34. In Guinea 175 of some 350 subdistrict health centres will operate under the Initiative by early 1991. The other half will be subject specifically to UNICEF support within the framework of the new country programme recommendation also being presented to the Executive Board at its 1991 session (E/ICEF/1991/P/L.8). Donor collaboration in Guinea, under the Ministry of Health Coordination, is significant. WHO and AfDB are supporting work to restructure the national drug supply system and the World Bank is active in PHC in one of the four regions of the country. Bilateral assistance from France is geared towards the revitalization of district hospitals and Medecins Sans Frontieres (Doctors Without Borders) is supporting Initiative action in several districts.

35. Guinea is well advanced in implementing the Initiative, having started in 1988, consolidating an earlier integration of several health programmes. The utilization of revitalized health centres continues to increase, although the level of utilization, as measured by the monitoring system in place, varies according to how near people live to the centres (see figure 3). Community financing is able, on average, to cover essential drug costs, but only around

85 per cent of other local operating costs. Community action has been strong in Guinea, aided by the decentralization policies of the Government under the Secretariat for Decentralization. A comprehensive evaluation of the Initiative was carried out at the end of 1990, which will highlight both the successes and shortcomings to date.

Figure 3



Kenya

36. Kenya has begun to implement the Initiative on a small scale in three clusters of villages in Kisumu District, and plans to extend implementation to 12 districts by 1991. The objective of the Initiative is to expand the CHW network, which is supported through the community management and financing of small village pharmacies, which stock nine commonly used drugs. This action is closely supervised by the district and local health system, which is beginning to benefit financially from the introduction of cost-sharing in health care delivery. Several donors have been consulted in this start-up action. WHO has sponsored a workshop to examine the formulation of a national drug policy. An Initiative plan for the next four years has been prepared, laying the basis for eventual nation-wide implementation.

Mali

37. Many developments in Mali are directly related to and form the basis of the Initiative, including decentralized health management in the Mopti Region and community-based nutrition activities at Segou. After close consultation with the World Bank, UNICEF and the Ministry of Health, the Government completed negotiations with the World Bank on its second health and population project, which will incorporate the major aspects of the Initiative. The project will cover five regions, with the International Development Association providing $23 million; and resources from other donors, such as USAID and EC, are also being mobilized. UNICEF technical support will take the form of one health adviser in each of the five regions to support local planning, management and community mobilization activities. UNICEF will also continue to support actions to help populations outside the reach of World Bank activities, particularly at Timbuktu and Gao.

Mauritania

38. In Mauritania the Initiative is being implemented in 28 villages in two trial zones, with local financing reaching levels sufficient to cover local operating costs, including essential drugs. A national strategy for village-based PHC is emerging from both this experience and other actions being carried out, particularly by NGOs. An operations research programme is looking closely at household health care expenditures, utilization of services and other key aspects affecting the delivery of health care. It is expected that by providing essential drugs under generic names, household health expenditures could be reduced as prices of drugs available in the country are considerably higher than those obtained through the UNICEF reimbursable procurement scheme.

Nigeria

39. Policy development in Nigeria has covered all major aspects of the Initiative, such as decentralization, essential drugs management and user financing. A National Consultative Committee for the Initiative meets twice a year to coordinate policy and implementation issues. Eight Local Government

Areas, out of a total of 453 in the country, covering around 4 million people, have already implemented the Initiative. The direct responsibility for implementing PHC lies with Local Government Area administrations, with federal and state ministries providing only technical support and supervision. The federal Government has, however, contributed the equivalent of $2 million specifically for Initiative actions in Local Government Areas.

40. Village development and health committees in the Local Government Areas where the Initiative has been introduced retain part of the revenues accrued from local financing. While a monitoring system is already functioning, some adjustments are being made for analyses to be carried out at Local Government Area, state and federal levels. Nigeria will be expanding the Initiative in upcoming years from the present small-scale action in four states to cover fully eight states, with UNICEF support, as described in the new country programme recommendation being presented to the Executive Board at its 1991 session (E/ICEF/1991/P/L.9).

Rwanda

41. The health infrastructure in Rwanda is relatively well-developed, with 45 per cent of health centres mission-owned and providing good quality services. The other 55 per cent of health centres are government-run, and although service quality is lower than that of mission-owned centres, their performance is considered relatively good compared to centres in other countries. Government-run health centres charge consultation fees, but the revenue flows into local government (commune) accounts and are not earmarked for health. This is one of the principal issues being addressed by the Initiative in the country. Close collaboration exists between UNICEF and WHO and several bilateral agencies, particularly those of Belgium and Germany, which are involved in similar actions in health.

Sierra Leone

42. The Initiative, which now constitutes the country's national health plan for MCH, is under way in 2 of the 12 districts of Sierra Leone, as well as in the Western Area where the capital, Freetown, is located. The UCI effort in 1990 created another 100 immunization units at the peripheral level, bringing the total to 550. These units form the basis on which the Initiative is implemented, with the introduction of ORT and growth monitoring and promotion and subsequently other priority health interventions. A total of 700 primary health units will eventually provide care to 90 per cent of the population.

43. The Initiative is based on an essential drugs programme that was started in 1986, supported by UNICEF and Africare, an NGO. Bilateral assistance from Germany has also supported PHC development in two other districts of the country. The drug supply and logistics system is well established in the country with the rehabilitation of district stores and the use of both kit and bulk systems. Funds are still not managed by the communities themselves, but held in district accounts for the eventual replenishment of essential drugs stocks. UNICEF has continued to advocate for greater community responsibility

in management through workshops and seminars with leaders at all levels, and there are indications that greater community co-management will gradually be introduced.

Togo

44. Togo has continued its preparatory work for implementing the Initiative, with 21 villages in two districts of the Maritime Region, Zio and Vo, now selected for start-up. Diagnostic and treatment charts have been prepared for use in dispensaries and by village health workers, with 26 and 8 essential drugs being managed in those two districts, respectively. UNICEF is collaborating closely with the World Bank, which is considering a loan of around $14 million for the rehabilitation and expansion of health infrastructure within the framework of structural adjustment. The Government of Germany is supporting trial action in community financing in five villages in the Central Region, and the Association Francaise des Volontaires de Progres is also involved with community financing in 70 villages in the Plateaux Region. This provides the potential for a significant advance in PHC in coming years.

B. Action in other countries in sub-Saharan Africa

45. An additional five countries have country programme recommendations being submitted to the 1991 Executive Board that include action on the Bamako Initiative. Ghana (E/ICEF/1991/P/L.7) was heavily involved in preparatory action in 1990 as an extension of the work under way in the programme to mitigate the social costs of adjustment, to which UNICEF contributed $2 million in essential drugs and related costs. Workshops were held on district management, operations research and essential drugs management. Baseline studies to assess drug use and services' utilization and to review the community clinics programme were carried out in five districts. The above efforts are expected to lead to improved service quality and thus to stimulate greater community action and control in 10 selected districts, eventually expanding to other districts.

46. Initial assessment and planning took place in Sao Tome and Principe in late 1989 and 1990. UNICEF has supported two consultancies, one to review the pharmaceutical sector and the other to conduct a two-week training course for national and local officials in all aspects of drug management and use. The Government has divided the country into seven districts, with a view to increasing efficiency in service delivery through decentralization, and UNICEF will concentrate its support in three of these districts as described in the country programme being presented to the Executive Board at its 1991 session (E/ICEF/1991/P/L.20).

47. The Sudan has completed a proposal to implement the Initiative in three health areas, following an intensive assessment by a national task force. This is contained in the new country programme recommendation (E/ICEF/1991/P/L.18).

48. An overall national plan for the Initiative in Zaire is still being developed and further action is proposed in the country programme recommendation (E/ICEF/1991/P/L.27). To date, UNICEF has met about 25 per cent of the external supply needs for essential drugs in the 11 regions of the country where health zones run local health services in a relatively autonomous way. Community financing operates throughout the country and the Initiative aims to strengthen the local committees to take a greater role in the management of funds and services. It is predicted that in the next two years, health care development in the country will be consolidated with the support of NGOs and several bilateral assistance programmes, including those of Canada, Germany, Italy and USAID.

49. Zambia has also included the Initiative in its country programme recommendation (E/ICEF/1991/P/L.4) for work to be carried out systematically in six districts over the medium term. Several aspects of the Initiative are still under study, including decentralization to the district level, which is only partially implemented at present. UNICEF has supported an in-depth assessment of the financing of the health sector, which includes community financing schemes in some areas and partially applied user charges in health facilities. Because government-run services are weak and under severe economic constraints, NGOs play a vital role in health care delivery. UNICEF has collaborated closely with them, particularly through the NGO Health Association, as well as with WHO and other major health sector supporters, such as bilateral agencies from the Netherlands and Sweden involved in an ongoing national essential drugs programme.

50. Another 11 countries deserve mention for their preparatory work, which in some cases is already leading to initial implementation in selected areas. Burkina Faso had been implementing an essential drugs programme for several years. This has led to an initial Bamako Initiative proposal, prepared by a national intersectoral coordinating committee. Although it is eventually envisaged that implementation will start in six districts, policy issues are still not fully resolved, particularly with regard to financing and community involvement.

51. Action in the Central African Republic started with a national seminar on the acceleration of PHC in September 1989. The decentralization of health care has been decreed by the Government, but public run health services are fragmented and little community financing exists. The Pan-African Development Institute, based in Cameroon, has assisted with a feasibility study on implementing the Initiative in the country, which has led to an operating plan for 1991 to begin actions in limited areas.

52. Some initial work has been undertaken in Chad, including the training of health workers, with a view to starting action in selected areas in five districts. Community financing does exist in some areas and is presently being studied. Within the basic services programme, supported by UNICEF, one subdistrict has introduced community financing on a trial basis to cover basic treatment costs. This has gained wide acceptability, with health committees managing the scheme.

53. In the Congo an important development was the launching of a medium-term economic and social plan for the period 1990-1994, which incorporates a number of the Initiative's principles, including decentralization, community management and financing and a proposal for the complete revision of essential drugs management. WHO and the bilateral development agencies from France and Germany participated in a seminar on the Initiative, which led to the formulation of an action plan for an initial phase of planning.

54. The first steps towards the implementation of the Bamako Initiative have been taken in Ethiopia, based on continuing support to the strengthening of district-level health care delivery systems. After a year's assessment, 12 districts have been selected for start-up, and the training of management teams, the preparation of district profiles and studies in community involvement and financing are occurring under the guidance of a national technical committee in the Ministry of Health.

55. The essential drugs programme in Guinea-Bissau received resources from the Swedish International Development Authority and UNICEF for the purchase of essential drugs. An evaluation mission began early in 1990 specifically to assess the potential for implementing the Initiative in the country, taking into account community pre-payment schemes that have existed for several years.

56. Lesotho has prepared an initial Initiative plan, which is currently being widely discussed in the country. The national task force that prepared the plan is a subcommittee of the National PHC Committee, which includes resource persons from WHO, UNICEF, the United Nations Development Programme (UNDP), USAID and Save the Children Fund. Liberia was also well advanced in its planning for the Initiative, based on extensive experience, especially on drug revolving funds, but all work stopped in May 1990 as a result of the civil war.

57. Madagascar has had relevant experience in community-based PHC over several years, with support from international agencies such as UNICEF and Swiss bilateral cooperation. Several studies have been undertaken on different approaches to community financing, such as payment for drugs and insurance schemes. A general study on the development of PHC is planned jointly by UNICEF and WHO, and the World Bank is supporting the Government in developing a comprehensive health sector strategy. It is expected that these efforts will lead to the startup of the Initiative in Madagascar.

58. A study sponsored by UNICEF in the United Republic of Tanzania on health services run by NGOs has documented the people's willingness to pay for services they perceive to be of good quality, including essential drugs. The study is under review by the Government, which has so far opposed any changes in its financing policy based on local development taxes. Uganda continues to place emphasis on approaching the Bamako Initiative from a global health sector financing perspective, which is a core component of the new country programme that began in 1990. Baseline surveys on household health budgets have been carried out by the National Task Force on Health Financing and a monitoring system has been put in place for community-based health projects. The capacity of health services to strengthen their operations is, however, seriously constrained by the HIV/AIDS situation.

C. Action in countries outside Africa

59. As has been reported in the past, increasing attention is being given to the Initiative by countries in areas outside Africa, and five countries have actually initiated planning action along the lines of the Initiative. Interest in the Initiative in Maldives is based on concerns to provide communities, particularly those on remote islands, with essential drugs. Some experience in community pharmacies exists and people generally place a high value on bought drugs. A first assessment of the relevance of the Initiative has pointed to the need for such health reforms as a greater orientation to PHC and increased decentralization in the management of the health care delivery system.

60. In Myanmar, the acute shortage of essential drugs has drastically reduced the credibility of the health services. During the formulation stage of a new national drug policy, it was estimated that only 10 per cent of the country's needs in essential drugs was being met. A period of assessment is starting on the relevance of the Initiative, particularly examining how communities can be involved in managing and financing basic health services. Over the next year, this will influence UNICEF support to the health sector in implementing the new country programme (E/ICEF/1991/P/L.14).

61. UNICEF has supported Nepal for some time in the provision of essential drugs to over 800 health posts in the country. Interest in moving towards an Initiative orientation came in late 1989 when a seminar bringing together government officials from various sectors, NGOs and international development agencies gave a positive assessment of the Initiative's relevance, taking into account many small community financing schemes already being implemented by NGOs. A national task force was set up and 5 of the 75 districts in the country were chosen for initial activities. Preparatory action includes in-depth situation analyses in each district, as well as a three-district survey on the health knowledge, attitudes and practices of the people.

62. In Peru, UNICEF is providing essential drugs to 30 districts of Lima and four other cities. Distribution is in accordance with Ministry of Health norms and through local women's organizations, which are already involved in CDD/ARI action. An assessment of the relevance of the Initiative to Peru in this context has focused on how community action can best help the health care delivery system.

63. An initial assessment made in Viet Nam late in 1989 opened the way for a phase of information collection on the delivery of basic health care in the country, including drug use patterns and the financing of the commune health system. Six districts in different topographical areas have been selected for initial activities, and district situation analyses have begun. UNICEF has supported this work with the financing of preparatory action, including a manual on rational drug use, the training of national- and district-level personnel and CHWs, and inputs of essential drugs. The eventual aim is to expand, in a first phase, the scope of this effort to about one quarter of the communes in the country as proposed in the new country programme recommendation (E/ICEF/1991/P/L.16).

IV. COORDINATION

64. UNICEF has emphasized the necessity of coordination among all partners in health care development in each country, the results of which are evident from the above description of in-country action. During the past year, national Bamako Initiative task forces have consolidated the dialogue between agencies that support health care development, including national and international NGOs. In a broader setting, the Pan-African Conference, sponsored by the WHO Regional Office for Africa in collaboration with UNICEF, was one of the high points of the past year, resulting in an overwhelming reaffirmation of the relevance of the Initiative to the African context and the commitment of countries to its implementation (see the annex to the present document).

65. Regular meetings on policy issues have continued to be held between the two UNICEF Regional Directors in Africa and the Director of the WHO Regional Office for Africa. There has been close contact between UNICEF and the WHO action programme on essential drugs, with WHO continuing to provide technical assistance to several countries in the establishment of national drug policies. Increasing contacts have also been made with the division of strengthening health systems, particularly with regard to health financing issues. Discussions have also continued with the United Nations Population Fund (UNFPA) on linkages, particularly the inclusion of family planning items in the essential drugs supply system.

66. The World Bank has increased its presence dramatically in sub-Saharan Africa during the last year, with regard to investment in PHC and essential drugs. Collaboration between UNICEF and the World Bank has already been established in Mali. In Nigeria, the World Bank will specifically support essential drugs actions linked to the strengthening of the health system at national and State levels, thus complementing the UNICEF focus on Local Government Areas. The World Bank will also cover 80 per cent of essential drugs needs in Sao Tome and Principe over the next three years, with UNICEF involved in many related training and logistics aspects of the work. Linkages between the World Bank and UNICEF are developing rapidly in Cameroon, Ghana, Madagascar and Togo. At a global level, the year has witnessed increased contact between the two agencies on country actions, as well as on policy and technical matters.

67. Increased contacts with bilateral development assistance agencies, both at headquarters and the country level, and international NGOs, have resulted in a greater consensus on the aims and benefits of the Initiative. UNICEF continues to attend various forums on issues relevant to the Initiative.

V. INFORMATION MANAGEMENT

68. The Bamako Initiative has continued to emphasize better information management, highlighting the increased use of operations research, monitoring and evaluation. Every country has embarked upon studies as part of the preparation phase. Although the study subjects have been diverse, reviews of

the pharmaceutical sector have been the most common, giving indications of the status of drug management in countries and emphasizing problems that exist in supply and distribution, from lack of foreign exchange and in competing with the private sector.

69. A more systematic approach to operations research is being implemented in several countries with a view to improving the design and implementation of the Initiative. A key background paper on operations research, specifically on the community financing of PHC development, was prepared by UNICEF, with the assistance of two African experts, and was presented to the Pan-African Conference. Specific operations research in four chiefdoms in Sierra Leone, covering 1,000 rural households, showed that buying drugs from peddlers is still less than one half the cost of treatment at a government primary health unit, although this can often be due to peddlers' willingness to sell only partial courses of treatment. High percentages of satisfaction, nevertheless, were obtained for such self-treatment, indicating a reasonable accuracy in self-diagnosis for common ailments or reasonably accurate advice from peddlers. People were willing to pay higher fees for government services provided they received an injection. It has not as yet been determined whether the high incidence of treatments that included injections was a result of patients' symptoms or a function of patient demand and ability to pay. The lack of money was by far the most frequent reason (around 60 per cent) why around 8 per cent of those who were ill chose no treatment.

70. In Mauritania, initial calculations from data collected in nine villages suggest that the Initiative will create considerable savings for households by establishing a better quality of care with essential drugs in the village. Savings will be realized because the number of journeys to higher level care facilities will be reduced and the need will be practically eliminated for people, other than the person in the community in charge of drugs supply and logistics, to travel long distances to buy drugs for treatment. In the more remote communities, savings of up to the equivalent of $6 per person per year could have a considerable impact on the family, enabling investment in other basic needs.

71. Considerable effort has been given to the establishment and refinement of monitoring systems. Data on Benin and Guinea, which appear in this report, are a direct consequence of this. Nigeria has also moved well ahead in the functioning of its monitoring system.

72. The first major evaluation of the Initiative took place in Benin in March 1990, with the participation of several national and international institutions. One very interesting observation was that mothers found health care too expensive if they perceived that funds generated were handled by health staff, but inexpensive if the funds were handled by the community. A similar evaluation took place in Guinea in December 1990.

73. The planned evaluation of the Initiative, sponsored by the Government of the United Kingdom of Great Britain and Northern Ireland, has entered its first phase. All the documentation that exists on the Initiative is being

reviewed to draw basic conclusions on its process and content. The second phase, planned for early spring 1991, will include a workshop to discuss the findings of the review and agree on country case studies, of which there are likely to be four, and which would constitute the third stage of the evaluation. A final round-up of all the main conclusions and recommendations should be ready by late 1991. A preliminary report on this evaluation is being made available to the Executive Board at its 1991 session.

VI. RESOURCES

74. As recommended by the Executive Board at its 1990 session, UNICEF has made more general resources available for the implementation of the Bamako Initiative by allocating them against the unfunded portions of approved supplementary funding proposals. In addition, some supplementary resources have been received, as follows:

	United States dollars
Government of Italy	770 000
Canadian UNICEF National Committee/Canadian International Development Agency	216 000
Government of Norway	500 000
Government of Nigeria	2 000 000
Total	3 486 000

75. To date, the general resources allocation, plus the supplementary funding, have created an overall Bamako Initiative development fund to date of $21,227,000. A recommendation to the Executive Board at its 1991 session proposes a continuation of general resources funding for global support to the Initiative (E/ICEF/1991/P/L.30).

76. Over $30 million remains unfunded and this amount will increase if new country programme recommendations are approved by the Executive Board at its 1991 session. The mobilization of resources is now at a critical stage as many countries are moving to expand the coverage of the Initiative. UNICEF has repeatedly stressed the need for international solidarity in this regard. Although there have been some positive signs, particularly with the closer involvement of bilateral development assistance agencies in the preparatory phases of Initiative country proposals, a major breakthrough in funding is still required to match the efforts being made under difficult circumstances by African Governments and communities.

Notes

1/ S. J. Fabricant and C. W. Kamara, "The financing of community services in Sierra Leone: initial results of an operations research study", Bamako Initiative technical report, UNICEF, 1990.

Annex

DECLARATION OF KINSHASA, ADOPTED BY THE PAN-AFRICAN CONFERENCE ON THE FINANCING OF COMMUNITY HEALTH ACTIVITIES, HELD AT KINSHASA FROM 25 TO 27 JUNE 1990*

DECLARATION

The Conference notes the current economic problems faced by all countries on the continent and commends the efforts of the various Governments and communities in improving the health of their peoples in spite of these economic problems. The Conference also acknowledges the efforts of the various United Nations, bilateral and multilateral agencies and non-governmental organizations for the improvement of the health care delivery systems of the continent.

The Conference reaffirms its commitment to primary health care (PHC) as a means of bringing health services to our peoples and reiterates that this PHC can only make a difference if it includes the following elements:

- Community participation;
- Appropriate technology;
- Intersectoral collaboration;
- Strengthening of support system;
- Integrated delivery of essential PHC services.

The Conference further reaffirms that the Bamako Initiative is a method for the attainment of the PHC goal of health for all by the year 2000 and that this Bamako Initiative strategy includes the following components:

- Community participation with a view to fostering self-reliance;
- Strengthening the management systems at the community and district levels with a view to making them more supportive of each other;
- Constant availability, rational prescription and use of good quality essential drugs;
- Community financing.

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* This Conference was organized by the World Health Organization (WHO) Regional Office for Africa with the support of UNICEF. There were over 150 participants, mainly technical experts in health and finance from practically every sub-Saharan African country. They reviewed experiences in community financing, in the strengthening of PHC management at district and community levels, and in the regular supply and rational use of essential drugs over the past two years since the African health ministers adopted the Bamako Initiative resolution.

The Conference recognizes that the implementation of the Bamako Initiative has permitted a significant increase in access to PHC which confirms the validity of the basic principles of the Bamako Initiative.

The Conference recommends that all Governments on the continent should rededicate themselves to the ideals of PHC as measured by:

- Policy shifts;
- Increased budgetary allocation with a foreign exchange component;
- Decentralization of activities within the global decentralization process.

The Conference further recommends that all donor agencies embrace the ideals of PHC as Africa's solution to its health needs by helping in:

- Procurement of good quality essential drugs;
- Strengthening the management and financial capabilities of the constituent countries.

The Conference recommends that communities mobilize themselves for the implementation of PHC on the basis of self-reliance.

The Conference urges WHO and UNICEF to publish periodically the number of countries implementing PHC under the Bamako Initiative strategy, the number of districts and populations covered.

The Conference recognizes the growing collaboration among African countries in the health sector with exchange of visits and experiences among these countries. This Conference is a further demonstration of this trend and the Conference strongly recommends the intensification of this trend.